Iowa Department of Human Services
Mental Health and Disability Service System Redesign
Mental Health Workgroup
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Briefing Paper: Trends and Considerations for Core Service Development

In 2003, the President's New Freedom Commission reported on the need to transform systems to ones that are recovery-oriented, produce positive system- and client-level outcomes, incorporate consumer choice, and support community integration. Since then, state mental health systems across the country have been working to provide continuums of evidence-based practices to service recipients. Further impetus for this change includes advances in the understanding of the interface of mental health and substance abuse with primary care and the impact of the national recession on states ability to sustain programs. With finite resources and increasing demand, states are challenged to deploy services that are cost effective and produce positive outcomes, and move away from services that are ineffective or have little research to support continued funding. This is complex for all states.

Consistent with the 1999 US Supreme Court *Olmstead* decision, current trends are toward community integration and away from congregate treatment or living arrangements. Several states are reducing state psychiatric hospital beds and implementing programs like Permanent Supportive Housing, ACT, and Peer-delivered services. Several states face *Olmstead* litigation from the US Department of Justice and/or state Protection & Advocacy groups.

States are trying to implement responsive continuums of care that consist of a broad range of Prevention, Early Intervention, Treatment and Recovery services. While trying to maintain a balanced system that is accessible to people no matter their needs, the trend is toward investing in more preventative (e.g. Health Homes) and recovery-oriented services (e.g. Supportive Housing, Illness Management & Recovery, Self-help, Supported Employment/Education). However, most states are also grappling with meeting the acute care needs for people with mental illness, and having sufficient, short-term, local in-patient capacity.

Several states have taken evidence-based practices to scale, including supportive housing, ACT, and peer-delivered services. Several states have also decreased or stopped funding to specific services that have not produced positive outcomes and have little research support. This includes some partial hospital or sheltered workshop programs and large congregate, residential settings.

Standardization of the delivery of evidence-based, core services is important to ensure consistency statewide and to use limited resources as effectively as possible. It gives funders and policymakers the ability to evaluate the cost effectiveness of services and fidelity to service

models. It is a mechanism to more effectively assess the needs in a system, justify increased resources and hold providers accountable. It is, however, complex and must be reflective of unique circumstances in states (i.e. urban versus rural, cultural and demographic diversity).

SAMHSA recognizes various evidence-based practices that when implemented in systems, produce positive outcomes. Each of the following practices also has an associated toolkit that can be used to design and implement these services locally.

- Permanent Supportive Housing
- Illness Management and Recovery
- Assertive Community Treatment
- Family Psychoeducation
- Consumer-operated Services
- Integrated Dual Diagnosis Treatment
- Supported Employment
- Medication Management

In a **"Description of a Good and Modern Addictions and Mental Health Service System"** SAMHSA identifies core components necessary to ensure a comprehensive continuum of services. Many of these services are covered by Medicaid funds, and can also be paid for by block grant or other funding sources (e.g. state general appropriations) for non-Medicaid eligible individuals or services. These categories include:

- Health Home/Physical Health Services
- Prevention (including Promotion)
- Engagement Services
- Outpatient Services
- Medication Services
- Community Support (Rehabilitative)
- Other Support (Habilitative)
- Intensive Support Services
- Out-of-Home Residential Services
- Acute Intensive Services
- Recovery Supports

Shaping a system requires the identification of evidence-based practices, but also includes incentives to encourage providers to deliver evidence-based services. For example, some states do not reimburse for emergency department care that is not considered an emergency. Magellan does not currently reimburse for ED use of the substance abuse population. Reimbursement rates for more desirable services may be enhanced. For example, an outpatient or community support service may be reimbursed better per unit of service than day treatment.

<u>Acute and Sub-acute Services</u>:

In addition to designing a continuum of core services, SF 525 specifically identifies the need to develop acute and sub-acute services. With Olmstead principles guiding state service delivery systems, serving people in the most integrated community settings possible is a priority for states. Several states continue to downsize their state hospitals, and are also moving toward permanent supportive housing models instead of developing group homes. However, acute care systems are strained, and states are working to ensure appropriate inpatient capacity while creating diversionary services necessary to reduce inpatient admissions and lengthy emergency department stays.

Most consumers do not need long term inpatient hospitalization. As a result, the use of state hospitals tends to be more for patients with forensic involvement or those requiring longer term treatment (i.e. > 30 days). In states where local inpatient capacity is insufficient, some state hospitals provide short-term, acute care treatment (i.e. 1-15 days). To the extent possible, sufficient local, short-term inpatient capacity should exist in order to locally provide acute care treatment. Some states are developing "intermediate" beds that provide extended inpatient for civilly committed patients who may need a longer stay than 10 days, but less than 45 days.

Less than 10% of all emergency department admissions are for people presenting with a mental illness. However, a significant number of people who are seen in an ED for mental illness ultimately end up hospitalized due to various factors, including unnecessary prudence on the part of clinicians or inaccessible community services due to hours of operation, geography, waiting lists, etc. Several states utilize various sub-acute services such as crisis mobile response teams designed to outreach individuals potentially in crisis as a result of a call from a family member, police, or one's self. The goal of this service is primarily to divert unnecessary admission, minimize ED costs of care, and to refer people to more appropriate, less costly services.

Other diversionary services that comprise acute care systems include early intervention, intensive outpatient services and crisis residential/respite. These services identify individuals who may be decompensating and provide immediate, more intensive services in order to help stabilize the individual and avert a true crisis. Usually, these services are operated off-site and away from hospitals and EDs. Consumers are often involved in peer delivered supports necessary to help the individual.

Nonetheless, any acute and sub-acute system of care should be easy to navigate for consumers, families and professionals, and should be administered as one system, no matter the payer.

Questions for Workgroup to Consider:

1. Should a continuum of Core Service Domains be mandated statewide?
2. Should specific Core Services within Core Service Domains be mandated statewide?
3. What should Core Service definitions include? Admission and Level of Functioning, Continuing Stay and Discharge criteria?
4. What should the continuum of Acute and Sub-acute care services consist of?
5. What services should have a greater presence in Iowa?
6. How can more desirable services be incentivized?